# 2010 Medical Benefits Highlights – I.B.E.W. Local 77

The purpose of this document is to help you make decisions; it is not a contract. Details are provided in your medical plan booklet at http://www.seattle.gov/personnel/resources/benefits_documents.asp.

| Group Health Cooperative (GHC) | City of Seattle Traditional Plan | | City of Seattle Preventive Plan | |
|---|---|---|---|---|
| | Preferred Provider | Non-Preferred Provider | Aetna In-Network | Out-of-Network |
| **Deductible** (per calendar year) | | | | |
| No deductible | $100 per person<br>$300 per family | $150 per person<br>$450 per family | Does not apply | $250 per person<br>$750 per family |
| **Annual Out of Pocket Maximum (OOP Max)** Excludes deductible, if applicable. Aetna Copays do not apply towards OOP Max. | | | | |
| $750 per person, $1,500 per family | $200 per person. Applies to 20% coinsurance | $1,200 per person. Applies to 40% coinsurance * | $500 per person<br>$1,000 per family (applies to emergency room copays) | $3,000 per person<br>$6,000 per family<br>Most costs paid in full after out-of-pocket maximum is paid.* |
| **Maximum Lifetime Benefits Payable** | | | | |
| None | $1,000,000 | | $1,000,000 | $1,000,000 |
| **Hospital Copay** | | | | |
| Paid at 100% | Paid at 100% | Paid at 100% | Paid at 100% | Paid at 100% |
| **Hospital Pre-admission Authorization** | | | | |
| Except for maternity or emergency admissions, must be authorized by GHC | Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission | | Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission | |
| **Choice of Providers** | | | | |
| All care and services must be approved and/or provided by GHC or GHC designated providers.<br>Members may self-refer to most GHC specialists. | Paid at 80% Paid at 60%<br>Outside the service area: Any licensed, qualified provider. Expenses paid based on Reasonable and Customary (R&C)* charges. You pay the difference between R&C and billed charges. | | Any Aetna contracted provider member. No primary care physician selection required. No referrals required. | Any licensed, qualified provider of your choice. Expenses paid based on reasonable* charges. You pay the difference between R&C and billed charges. |
| **COVERED EXPENSES** | | | | |
| **Acupuncture** | | | | |
| Paid at 100% after $5 copay. Self-referred up to 8 visits per condition per calendar year. Additional visits with PCP referral. | Paid at 80% Paid at 60%<br>Maximum of 12 visits per calendar year. | | Paid at 100% after $5 copay | Paid at 70% |
| **Alcohol/Drug Abuse Treatment** | | | | |
| Inpatient: Paid at 100%<br>Outpatient: Paid at 100% after $5 copay | Paid at 80% for inpatient and outpatient | Paid at 80% for inpatient and outpatient | Inpatient: Paid at 100%<br>Outpatient: Paid at 100% after $5 copay | Inpatient: Paid at 70%<br>Outpatient: Paid at 70% |

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| **Contraceptives** | | | | |
| For contraceptive drugs and devices, see Prescription Drug benefit | Oral contraceptive drugs: see Prescription Drug benefit. Contraceptive devices and other prescription contraceptive products covered as medical benefit. | Oral contraceptive drugs: not covered. Contraceptive devices and other prescription contraceptive products covered as medical benefit. | Oral contraceptive drugs: see Prescription Drug benefit. Contraceptive devices and other prescription contraceptive products covered as medical benefit. | Oral contraceptive drugs: not covered. Contraceptive devices and other prescription contraceptive products covered as medical benefit. |
| **Durable Medical Equipment** | | | | |
| Paid at 80% | Paid at 80% | Paid at 80% | Paid at 100% | Paid at 70% |
| | Maximum benefit unlimited for in-network and out-of-network combined. | | Maximum benefit unlimited for in-network and out-of-network combined. | |
| **Emergency Medical Care** | | | | |
| ➢ **Urgent Care Clinic** | | | | |
| Paid at 100% after $5 copay | Paid at 80% | Paid at 80% | Paid at 100% | Paid at 70% |
| ➢ **Emergency Room (copays waived if admitted)** | | | | |
| GHC facility: Paid at 100% after $50 copay (waived if admitted) Non-GHC facility: Paid at 100% after $100 deductible (waived if admitted) | Paid at 80%. | Paid the same as in-network except if it's non-emergency, then it's 60% | Paid at 100% after $50 copay (waived if admitted.) Urgent Care paid at 100% after $35 copay. | Paid the same as in-network except if it's non-emergency, then it's 70% after $50 copay. (waived if admitted). |
| ➢ **Ambulance** | | | | |
| Paid at 80%. GHC-initiated non-emergency transfers are paid at 100% | Paid at 80% when medically necessary. | | Ground ambulance paid at 100% when medically necessary. Non-emergency transportation must be approved in advance by Aetna. | |
| **Hospital Inpatient** | | | | |
| Paid at 100% . | Paid at 80% | Paid at 60% | Paid at 100% | Paid at 70% |
| **Hospital Outpatient** | | | | |
| Paid at 100% after $5 copay | Paid at 80% | Paid at 60% | Paid at 100% after $5 copay | Paid at 70% |
| **Hospice** | | | | |
| Paid at 100% when authorized | Paid at 90%. Lifetime maximum of $10,000 or 6 months, whichever is greater. 14 day inpatient limit per 6 month period. 120 hour limitation for skilled nursing care. | | Paid at 100% Maximum of 6 months for inpatient and outpatient combined. | Not covered |
| **Maternity Care (**delivery & related hospital) | | | | |
| Paid at 100% | Paid at 80% | Paid at 60% | Paid at 100% | Paid at 70% |
| **Maternity Care** (prenatal and postpartum) | | | | |
| Paid at 100% after $5 copay | Paid at 80% | Paid at 60% | Paid at 100% after $5 copay | Paid at 70% |
| **Mental Health Care** (inpatient) | | | | |
| Paid at 100% | Paid at 80% | Paid at 60% | Paid at 100% | Paid at 70% |

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| **Mental Health Care** (outpatient) | | | | |
| Paid at 100% after $5 copay per individual, family or couple session. Copays apply to the annual out-of-pocket maximum. | Paid at 80%. Expenses apply to the annual out-of-pocket coinsurance maximum. | Paid at 60% Expenses apply to the annual out-of-pocket coinsurance maximum. | Paid at 100% after $5 copay Copays do not apply to the annual out-of-pocket maximum | Paid at 70% Coinsurance applies to the annual out-of-pocket maximum. |
| **Physician Office Visit** | | | | |
| $5 copay | Paid at 80% | Paid at 60% | Paid at 100% | Paid at 70% |
| **Prescription Drugs** (retail) | | | | |
| For a 30-day supply: $5 copay.<br>Contraceptive drugs and devices are covered subject to the pharmacy copay.<br>Copays do not apply to the annual out-of-pocket maximum. | For a 34-day supply or 100 unit supply (whichever is greater): $8 copay. You pay the difference between generic and name-brand.<br>Oral contraceptives are covered.<br>Contraceptive devices and other prescription contraceptive products are covered under the medical plan benefit.<br>Copays do not apply to out-of-pocket maximum. Non-formulary drugs not covered. | Not covered | For a 31-day supply:<br>Generic: $5 copay<br>Preferred brand: $10 copay<br>Non-preferred drugs: $25 copay<br>Oral contraceptives are covered.<br>Contraceptive devices and other prescription contraceptive products are covered under the medical plan benefit. Copays do not apply to out-of-pocket maximum. | Not covered |
| **Prescription Drugs** (mail order) | | | | |
| 3x $5 copay per 90-day supply | For a 90-day supply:<br>$16 copay.<br>Non-formulary drugs are not covered | Not covered | For a 90-day supply:<br>Generic: $10 copay<br>Preferred brand: $20 copay<br>Non-preferred drugs: $50 copay | Not covered |
| **Preventive Care** | | | | |
| Paid at 100% for preventive care visits, most immunizations, hearing exams, eye exams and mammograms. | Paid at 100% (deductible waived)<br>Maximum of $300 per calendar year.<br>Mammograms paid at 80%. | Paid at 60% for mammograms, deductible waived. | Paid at 100% for periodic check-ups, well child care, immunizations, well woman care and mammograms. | Paid at 70% for well woman care and mammograms. No other preventive services covered. |
| **Rehabilitation Services** (inpatient) | | | | |
| Paid at 100%<br>Maximum of 60 days per condition per calendar year for all types of rehabilitation. | Paid at 80%<br>Maximum of $50,000 per condition per calendar year for preferred and participating services combined. | Paid at 60% | Paid at 100% | Paid at 70% |
| **Rehabilitation Services** (outpatient) | | | | |
| Paid at 100% after $5 copay<br>Maximum of 60 days per condition per calendar year for all types of rehabilitation. | Paid at 80%<br>Coinsurance does not apply to out-of-pocket maximum.<br>Maximum calendar year benefit of $2,000. | | Paid at 100% after $5 copay<br>Benefit includes physical/massage, speech, occupational and cardiac/pulmonary therapy. Coinsurance does apply to the annual out-of-pocket maximum. Maximum of 20 visits per calendar year for each of the above listed benefits for in-network and out-of-network combined. | Paid at 70% |

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| **Skilled Nursing Facility** | | |
| Paid at 100%; 60 day maximum per calendar year (in addition to coverage in lieu of hospitalization) | Paid at 80%<br>Maximum of 90 days per calendar year | Paid at 100% Paid at 70%<br>Maximum of 120 days per calendar year for in-network and out-of-network combined |
| **Smoking Cessation** | | |
| Paid at 100% for individual/group sessions through Free and Clear. Nicotine replacement therapy included in Prescription Drugs benefit. No copay on all smoking cessation prescription drugs. | Lifetime maximum of one 90-day supply of smoking cessation aids or drugs. See Prescription Drugs, retail. Not covered | Not covered |
| **Spinal Manipulations** | | |
| Paid at 100% after $5 copay. Self-referral to GHC designated providers. Must meet GHC protocol. Maximum of 10 visits per calendar year. | Paid at 80%<br>Maximum of 10 visits per calendar year | Paid at 100% after $5 copay. Paid at 70%<br>Maximum of 20 visits per calendar year for in-network and out-of-network combined |
| **Sterilization Procedures** | | |
| Vasectomy and tubal ligation covered subject to $5 copay | Paid at 80% Paid at 60% | Inpatient: Paid at 100% Paid at 70%<br>Outpatient: Paid at 100% after $5 copay. |
| **Tooth Injury** (due to accident) | | |
| Not covered | Paid at 80%. Maximum $600 per occurrence | Inpatient: Paid at 100% Paid at 70%<br>Outpatient: Paid at 100% after $5 copay. Maximum $600 per occurence<br>Maximum $600 per occurence |
| **Vision Hardware** | | |
| Covered under Vision Service Plan | Covered under Vision Service Plan | Covered under Vision Service Plan |
| **X-ray and Lab Tests** | | |
| Paid at 100% | Paid at 80% Paid at 60% | Paid at 100% Paid at 70% |

* Applies to Aetna -- Recognized charges are the lower of the provider's usual charge for performing a service, and the charge Aetna determines to be the recognized charge percentage in the geographic area where the service is provided.

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